PRINTED: 08/24/2012 FORM APPROVED OMB NO. 0938-0391

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | | PLE CONSTRUCTION G | (X3) DATE SUR COMPLETI | |
|--------------------------|--|---|--------------------|-----|--|---------------------------|----------------------------|
| | | 012649 | B. WIN | G_ | | 08/0: | 3/2012 |
| | COVIDER OR SUPPLIER | · | , | ١ | REET ADDRESS, CITY, STATE, ZIP CODE 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| G 000 | INITIAL COMMENTS | | G | 000 | | | |
| | This visit was for a hocertification. This was | ome health initial medicaid an extended survey. | | | | | |
| | Survey dates: 7/31/12 | 2-8/3/12 | | | | | |
| | Facility # 012649 | | | | | | |
| | Survey Team: | | | | | | |
| | Dawn Snider, RN, PH Linda Dubak, RN, PH | | | | | | |
| | Census Service Type | : | | | | | |
| | Skilled Patients: 7 Home Health Aide Or Total: 12 | nly Patients: 0 | | | | | |
| | Sample: RR w/o HV: 7 RR w HV: 5 Total: 12 | | | | | | |
| | with the Conditions of 484.14 Organization, Administration; 484.1 Personnel; 484.18: A of Care, and Medical Health Aide Services; and 484.52 Evaluatio | d to be out of compliance f Participation 42 CFR Services, and 6 Group of Professional cceptance of Patients, Plan Supervision; 484.36: Home 484.48: Clinical Records; n of the Agency's Program. e Elder, MSN, BSN, RN | | | | | |
| G 108 | Au | gust 15, 2012 FO BE INFORMED AND | G | 108 | | | |
| L ABORATORY | I DIRECTOR'S OR PROVIDER/S | SUPPLIER REPRESENTATIVE'S SIGNATURE | : | | TITI F | | (X6) DATE |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 | |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | : | ' | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 1727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| G 108 | The patient has the ri advance about the ca any changes in the ca the disciplines that wi frequency of visits proof the HHA must advise any change in the plais made. This STANDARD is ready because the disciplines that wi frequency of visits proof the HHA must advise any change in the plais made. This STANDARD is ready because the plais made on clinical record review, the agency fa was informed of the fidocuments were date clinical records review the potential to affect. Findings include: 1. Clinical record #1, include documentation informed of the frequency with a check mark, "Snext to "other": "Pt. [proof the frequency to include documentation informed of the frequency furnished. | ght to be informed, in are to be furnished, and of are to be furnished. It the patient in advance of all furnish care, and the oposed to be furnished. It the patient in advance of an of care before the change Into | G | 108 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|------|--|-------------------------------|----------------------------|
| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | : | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| | to include documental informed of the frequency of the frequency of the frequency of the frequency of the patient on 4/19/12 documentation the patient of | skilled nurse." The and unsigned. start of care 3/14/12, failed ation the patient had been ency of visits and the care to start of care 9/9/11, failed to in the patient had been ency of visits and the care to be ency policy titled "2.5 SSESSMENT INITIAL assessment" states, "b. or care and services and the idea to be provided" Exp policy titled "2.13 and the care to be provided" Exp policy titled "2.13 and the care to be ency policy titled "2.14 and the care to be ency policy titled "2.15 and the care to be ency policy titled " | | 1111 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | B. WING | | | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 111 | Continued From page | e 3 | G | 111 | | | |
| | Based on document interview, the agency | not met as evidenced by: and policy review and failed to ensure clinical d from potential theft for 1 of tential to affect all the | | | | | |
| | Findings include: | | | | | | |
| | the administrator was | s dated 3/13/12 evidenced storing clinical records in hen it was broken into and stolen. | | | | | |
| | | PM, the administrator eviously had clinical records of her car. | | | | | |
| G 113 | Agency Use of Recor Entries" states, "All cl contents thereof are of protected from loss a / client clinical records secure manner as to client / patient data the off site." 484.10(e)(1) PATIENT | r titled "Confidentiality / rds / Authority to Make inical records and the confidential and will be nd unauthorized use. Patient s will be maintained in a maintain the integrity of the irough routine backups on or T LIABILITY FOR PAYMENT ght to be advised, before | G | 113 | | | |
| | for the HHA services Medicare or other sou | e extent to which payment may be expected from urces, and the extent to be required from the patient. | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 012649 | B. WIN | G | | — 08/03/2 | | |
| | ROVIDER OR SUPPLIER | | • | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 113 | Based on clinical recreview, the agency far was notified of the exbe expected from Me and the extent to whither from the patient for 7 with the potential to a patients. (#2-8) Findings include: 1. Clinical record #2, included a form titled Financial Agreement' evidence the patient payment information. payment information. 2. Clinical record #3, form titled "Consent formation. None of information. None of information had been 3. Clinical record #4, form titled "Consent formation. None of information. None of information. None of information had been 4. Clinical record #5, form titled "Consent formation had been 4. Clinical record #5, form titled "Consent formation had been 4. Clinical record #5, form titled "Consent formation had been 4. Clinical record #5, form titled "Consent formation forma | start of care (SOC) 5/15/12, "Consent for Treatment and Financial 24/12 that failed to evidence ned of any payment to grayment and Financial 14/12 that failed to evidence ned of any payment to mpleted. SOC 3/14/12, included a or Treatment and Financial 14/12 that failed to evidence ned of any payment to empleted. | G | 1113 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | ING | | | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | : | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
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| G 113 | information. None of the information had been so that the patient was information. None of information. None of information had been so the patient was information had been so the patient was information had been so the patient was information. None of information. None of information. None of information had been so the patient was information. None of information had been so the patient was information had been so the patient was information. The patient was information had been so the patient was information had been so the patient was information. The patient was information had been so the patient was information had been so the patient was information. | the lines for payment completed. SOC 3/15/12, included a or Treatment and Financial 15/12 that failed to evidence ned of any payment the lines for payment completed. SOC 3/15/12, included a or Treatment and Financial 15/12 that failed to evidence ned of any payment the lines for payment completed. SOC 9/9/11, included a or Treatment and Financial 15/12 that failed to evidence ned of any payment the lines for payment completed. | G | 113 | | | |
| G 114 | ACCEPTANCE OF P. "4. When a request is services, the patient/c acceptance as a patie Homebound, if Medic insurance requirement 484.10(e)(1(i-iii) PATI PAYMENT Before the care is init the patient, orally and (i) The extent to which | nts are met." ENT LIABILITY FOR iated, the HHA must inform | G | 114 | | | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1, , | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WING | S | | 08/0 | 3/2012 | |
| | OVIDER OR SUPPLIER GRACE MY CHOICE IN | С | | 8727 CO | DRESS, CITY, STATE, ZIP CODE MMERCE PARK PL STE L APOLIS, IN 46268 | 1 00/0 | 0/2012 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (| PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| G 114 | (ii) The charges for so | ram known to the HHA; ervices that will not be | G ? | 14 | | | | |
| | Based on clinical re- review, the agency fa was notified of the ex- be expected from Me and the extent to wh from the patient for 7 | not met as evidenced by: cord review and policy ailed to ensure the patient ktent to which payment may edicare and other sources ich payment may be required of 7 active records reviewed affect all the agency's | | | | | | |
| | Findings include: | | | | | | | |
| | included a form titled Financial Agreement evidence the patient payment information payment information | start of care (SOC) 5/15/12, I "Consent for Treatment and " dated 5/15/12 that failed to was informed of any . None of the lines for had been completed. | | | | | | |
| | form titled "Consent Agreement" dated 1/ the patient was infor | f the lines for payment | | | | | | |
| | form titled "Consent Agreement" dated 3/ the patient was infor | SOC 3/14/12, included a for Treatment and Financial 14/12 that failed to evidence med of any payment f the lines for payment | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | <u> </u> | | | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | | • | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| G 114 | information had been 4. Clinical record # 5, form titled "Consent for Agreement" dated 3/1 the patient was inform information. None of tinformation had been 5. Clinical record # 6, form titled "Consent for Agreement" dated 5/1 the patient was inform information. None of information had been 6. Clinical record #7, form titled "Consent for Agreement" dated 3/1 the patient was inform information. None of information had been 7. Clinical record # 8, form titled "Consent for Agreement" dated 7/5 the patient was inform information. None of information. None of information had been 8. The undated policy ACCEPTANCE OF Policy "4. When a request is services, the patient/consent acceptance as a patient Homebound, if Medicinsurance requirement." | SOC 3/14/12, included a par Treatment and Financial 14/12 that failed to evidence and of any payment the lines for payment completed. SOC 3/15/12, included a par Treatment and Financial 15/12 that failed to evidence and of any payment the lines for payment completed. SOC 3/15/12, included a par Treatment and Financial 15/12 that failed to evidence and of any payment the lines for payment completed. SOC 3/15/12, included a par Treatment and Financial 15/12 that failed to evidence and of any payment the lines for payment completed. SOC 9/9/11, included a par Treatment and Financial 15/11 that failed to evidence and of any payment the lines for payment the lines for payment the lines for payment the lines for payment completed. Attitled "2.9 REFERRAL AND ATIENTS/CLIENTS" states, are received for home health client will be considered for early client if he/she is: a. are billing or private atts are met." | | 1114 | | | |
| G 121 | 484.12(c) COMPLIAN | NCE W/ ACCEPTED | G | 121 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | A. BUIL | DING _ | TRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 012649 | B. WING | 3 | | 08/0 | 3/2012 | |
| | OVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | | | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| G 121 | professional standard | | G · | 121 | | | | |
| | Based on clinical rec interview, and observ ensure agency policie the provision of servic within the scope of th | not met as evidenced by: ord review, policy review, ation, the agency failed to es were followed regarding ces and the nurse acted e Indiana nurse practice act ls reviewed with the potential y's patients. (#4) | | | | | | |
| | Findings include:. | | | | | | | |
| | RECORDS CONTEN following information; b. Physician's orders (4) Medications (5) Tr Physician's Orders a. occur before the orde documented in the cli request is to be sent to | y titled "2.57 CLINICAL TS" states, "It includes the 3. Physician's Orders are to cover the following: reatment 4. Change of Changes in orders that rs are renewed are to be nical record and a written to obtain the orders in are to be signed by the ays." | | | | | | |
| | CRITERIA" states, "4 skilled care must be u physician. The physic include orders for all s | sian's plan of treatment shall services except household, es unless such orders are | | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | LE CONSTRUCTION G | (X3) DATE SUR COMPLETE | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | ROVIDER OR SUPPLIER | | • | 8 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
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| G 121 | evidenced medical plasmedical diagnoses ar care and home health been completed by the nursing. The plans of physician ordered the periods 3/14/12 - 5/13/7/12/12 - 9/9/12. A. The plan of care 3/14/12 - 5/13/12 inclusive mental retardatinc ontinent of urine an identified the registered time a week for 8 week progress; monitor dies on fall risk, meds, and The home health aide for 8 weeks and was all ADLs [activities of face to face fall risk mediation of the plan of doctor was called 5/4, twice on 4/18/12 and faxed on that day. The [doctor] has send [sice to face were written by of nursing and the plasmed on the plan orders were written by of nursing and the plasmed the physician. | start of care date 3/14/12, ans of care including and orders for skilled nursing a aide services that had e administrator / director of f care failed to evidence the care for the certification 3/12, 5/13/12 - 7/11/12, and the for the certification period uded the diagnoses of ation, flib foot, and | G | 121 | | | |

| | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | PLE CONSTRUCTION G | (X3) DATE SUR COMPLETE | |
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| G 121 | severe mental retardate food. The plan of car registered nurse to proveek for 8 weeks to "[unknown word] skin. assessment. educate assesses constipation ordered. The home his services 5 hours a da weeks. The aide was provide guidance, mostool, fall precautions The record evide as ordered. A nurse's states, "Please note to give [patient] care. His request but the [family him care as reported. by the administrator / plan of care was not so the care give of care was not so the care giver on fall risk, and draw care plan for home health aide was a day five days a wee and implement all AD patient tidy. The order | aided the diagnoses of ation, incontinent, and flib are included orders for the ovide services 2 hours a supervise progress of all cardiopulmonary on diet fall precautions" and to perform enema as ealth aide was to provide by for 5 days a week for 8 at to help with all ADLs, nitor patient from eating and report any incident. Inced the care was provided anote dated 6/5/12 at 3 PM and doctor verbally denied to be has refused to sign due to be member] has declines [sic]. The orders were written director of nursing and the signed by the physician. If or the certification period ded the diagnoses of severe continent of stool and urine, the registered nurse was to be for 8 weeks to supervise assess skin care, educate educate nutrition, toileting, or any new episode. The sto provide services 4 hours as a necessary and keep are were written by the rof nursing and the plan of | G | 121 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | LTIPLE CONSTRU | JCTION | (X3) DATE SUF COMPLET | |
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| | | 012649 | B. WING | | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | | | 8727 COMME | SS, CITY, STATE, ZIP CODE RCE PARK PL STE L ILIS, IN 46268 | | |
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| G 121 | visit, the administrato completed a skilled in patient. E. On 8/2/2012 at director of nursing incomultiple attempts to chad not been able to the patient was trying provide care for the patient was trying providing care without within the legal bound 484.14 ORGANIZATI ADMINISTRATION | 2:30 PM, during the home r / director of nursing ursing assessment on the 4:20 PM, the administrator / dicated she had made contact the physician and get orders and the mother of to find another physician to latient. IAC 2-2-1, 2-2-2, and 2-2-3 actice act) identifies the only make nursing lal ones, and must function daries of nursing practice. It a doctor's order is not daries of nursing practice. ON, SERVICES & | G ´ | | | | |
| | Based on document record review, and podetermined the agend organizational chart vagency (See G 123), board had met to per 1 agency (See G 130 minutes evidenced the reviewed the bylaws. | cy failed to ensure the vas accurate for 1 of 1 the professional advisory form their functions for 1 of 1), the governing body e governing body had for 1 of 1 agency (See 131), was accurate for 1 of 1 | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | LTIPLE CONSTRUCTION | | (X3) DATE SUR COMPLETE | |
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| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | c | | STREET ADDRESS, CITY, 8727 COMMERCE PA INDIANAPOLIS, IN | RK PL STE L | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CO | DER'S PLAN OF CORRECTI DRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| G 122 | nursing was available knowledge of the age its own personnel pol files reviewed (See Coordination of care oproviding services for reviewed of patients rentities (See G 143 at The cumulative effect resulted in the agency requirements of this CCFR 484.14 Organization. 484.14 ORGANIZATI ADMINISTRATION Organization, service control, and lines of a | or/ alternate director of e and had a working ency (See G 137), it followed dicies for 4 of 4 employee G 141), and failed to ensure occurred with other entities or 2 of 2 patient records receiving services from other and G 144). It of these systemic problems by's inability to meet the Condition of Participation 42 ation, Services, and ION, SERVICES & | G 1 | | | | |
| | Based on document agency failed to ensu | not met as evidenced by: review and interview, the ure the organizational chart f 1 agency with the potential nts of the agency. | | | | | |
| | | ated organizational chart has a Disaster Coordinator, | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ` ' | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WING | i | | 03/2012 | |
| | OVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STA 8727 COMMERCE PARK INDIANAPOLIS, IN 462 | ATE, ZIP CODE PL STE L | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRI | R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| G 123 | Continued From page had licensed practical physical therapy and | nurse, and provided | G 1 | 23 | | | |
| G 130 | indicated she was not nursing and home her of financial constraints. Disaster Coordinator 3. On 8/2/12 at 9:17 A | _ | G 1 | 30 | | | |
| G 130 | , , | rranges for professional | | 30 | | | |
| | Based on document and interview, the age professional advisory members and had me | not met as evidenced by: review and policy review ency failed to ensure the board included the required et to perform their functions the potential to affect all the e agency. | | | | | |
| | agency has a profess Two 2 people were or Committee. Both of the | izational chart indicates the ional advisory committee. In the Professional Advisory the people listed were thes were identified as being | | | | | |
| | 2. Review of agency evidence any minutes | | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--------------------|--|--|-------------------------------|----------------------------|
| | | 012649 | B. WING | <u></u> | | 08/0 | 3/2012 |
| NAME OF PROVID | DER OR SUPPLIER | | | STREET ADDRESS, CITY, 8727 COMMERCE PAI INDIANAPOLIS, IN | RK PL STE L | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CC | DER'S PLAN OF CORRECTI DRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| groon 3. The star me CO rev ser poly treat per 4. Co indown me 5. direct Advisor Advis | etes, "Meetings: The set at least twice yet at least twice yet of MMITTEE DUTIES view the Agency porvices offered, admilicies, medical superatment, emergency resonnel qualification On 8/3/12 at 4:20 Folicated there had be setings. On 7/31/12 at 1:25 ector of nursing indivisory Committee hiting for the Medical 4.14(b) GOVERNING egoverning body a views written bylaws uivalent. It is STANDARD is not a seed on document to a agency failed to enutes evidenced the viewed the bylaws of tential to affect all the indings include: | titled "1.15 VISORY COMMITTEE" e Advisory Committee shall arly. ADVISORY S: 1. Establish and annually licies governing the scope of ission and discharge ervision and plans of v care, clinical records, and ns." PM, the director of nurses een no professional advisory FPM, the administrator / icated the Professional had not met as they were hid Certification Survey. NG BODY | G - | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|-----|--|-------------------------------|----------------------------|
| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 131 | the governing body. 2. The undated policy GOVERNANCE" state shall operate within the By-laws, which are according to the government of th | -laws had been reviewed by titled "1.10 es, "By-Laws: The agency | G | 131 | | | |
| G 135 | 484.14(c) ADMINISTI The administrator, wh supervising physician under paragraph (d) of | | G | 135 | | | |
| | Based on document administrator failed to | not met as evidenced by: review and interview, the ensure its brochure was ency with the potential to patients. | | | | | |
| | agency provided pers companions, and lice 2. On 7/31/12 at 5:00 indicated she is not predirector of nursing statch the nurse and the hor indicated the agency nurses. | had no licensed practical | | | | | |
| G 137 | 484.14(c) ADMINISTI | RATOR | G | 137 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|-------------------|-----|---|-------------------------------|----------------------------|
| | | 012649 | B. WING | | · | 00/0 | 3/2012 |
| | COVIDER OR SUPPLIER GRACE MY CHOICE INC | l | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | <u> </u> 06/0: | 3/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 137 | Continued From page A qualified person is a the absence of the ac | authorized in writing to act in | G | 137 | | | |
| | Based on policy and interview, the agency alternate administrate nursing was available knowledge of the age | or/ alternate director of | | | | | |
| | of nursing indicated s a second part time jol | 15 AM, the alternate director he had another full time and b and did not know the ided any patient care. | | | | | |
| | OF NEW HOME CAR Agency staff will parti organized orientation orientation period will in duration and is des | be approximately 12 weeks igned to provide each new sential information relative to | | | | | |
| | 3. The personnel reco administrator / alterna to evidence documen description or oriental administrator / alterna positions. | ate director of nursing failed tation of a signed job tion for the alternate | | | | | |
| G 141 | 484.14(e) PERSONN | IEL POLICIES | G | 141 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|------|---|-------------------------------|----------------------------|
| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER | | . | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | 1 00/0 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| G 141 | policies. Personnel records inclicensure that are kep This STANDARD is r Based on personnel and interview, the age followed its own person | and patient care are iate, written personnel slude qualifications and t current. The contract as evidenced by: record review, policy review, ency failed to ensure it connel policies for 4 of 4 ed (A, B, C, and D) with the | G | 1141 | | | |
| | RECORDS" states, "Free contain the following: indicates receipt of or 2. Verification of qualities assigned in on-line lice professional employer egistration, and celling care workers 3. including Mantoux resheld in a separate file list." 2. The undated policy OF NEW HOME CARPROCEDURE: 1. The designee will ensure the participates in the oriental care in the oriental care in the contained and the contained and the contained are contained as the contained ar | rtificate of training for all Records of a health nature, sults or chest x-ray results () 12. An orientation check titled '4.14 ORIENTATION E STAFF" states, " e Agency Administrator or that every new staff member | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | PLE CONSTRUCTION | (X3) DATE SUF COMPLET | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER | ; | | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | , | <i></i> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 141 | record shall be maintagersonnel file, if the hamber that the record must inclue examination certifying communicable diseas undertaken with a Maland is required of state Mantoux test within the Mantoux test within the Mantoux test within the Prior to an offer of empersonnel and volunte conduct a state criminate Nurse Aide Regist Misconduct Registry thas a criminal convict certain conduct The history record must be [sic] employment Donotification must be known personnel file." 5. Personnel record to evidence the employens the position of admining nursing/registered nurs | "3. Each employee's health ained in a separate as direct patient contact. Ide: a. A physical that the employee is free of ite. b. Tuberculosis test in intoux intradermal skin test if that has not had a ine past six months." It titled "4.10 CRIMINAL CK" states, "POLICY: 1. Imployment to unlicensed iters, the Agency will inal history check and search try, and the Employee iter of determine if that person item or has committed item and e within 72 hours or recumentation of this item and the employee's A, date of hire 6/1/11, failed byte had been oriented to estrator / director of item. B, date of hire 2/10/12, failed byte had been oriented to ite administrator / alternate gistered nurse and a dated item position of alternate ite director of | G | 141 | | | |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | LE CONSTRUCTION | (X3) DATE SUF COMPLET | |
|--------------------------|---|---|---------------------|--|--------------------------|----------------------------|
| | | | A. BUILDING | <u> </u> | | |
| | | 012649 | B. WING | | 08/0 | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 141 | as a home health aid for tuberculosis. 8. Personnel record I to evidence the employers the position of home background check, a registered on the homa physical exam that communicable disease for tuberculosis. 9. On 8/3/12 at 2:15 If director of nursing incommunicable disease for tuberculosis. 484.14(g) COORDIN SERVICES All personnel furnishing to ensure that their effectively and support the plan of care. This STANDARD is a Based on clinical recoview, the agency fareof care occurred with services for 2 of 2 (# reviewed of patients a entities with the poter receiving services from Findings include: | oyee had a dated job stered on the state registry e, and an annual screening D, date of hire 2/24/12, failed oyee had been oriented to health aide, a criminal dated job description, was ne health aide state registry, included free of se, and an annual screening PM, the administrator / dicated that A, B, C, and D he agency. ATION OF PATIENT Ing services maintain liaison fforts are coordinated art the objectives outlined in Inot met as evidenced by: cord review and policy hiled to ensure coordination other entities providing 2 and 9) patient records receiving services from other intial to affect all patients im another entity. | G 141 | | | |
| | 1. The undated policy | / titled "2.30 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | IG | | 08/0: | 3/2012 |
| | COVIDER OR SUPPLIER | : | 1 | 8 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 143 | COORDINATION OF staff professional nurs following: a. The profe home care services communication betwee caregivers and docume client record e. Schee case conferences." 2. Clinical record #2, 5/15/12-7/13/12 and 7 note dated 5/9/12 at 1 worker. The docume Communication Log" she clarified only RN report to MD, and call findings." The note wanursing. The clinical any communication or regarding the social worker, or that care with the social w social worker, or that care with the social w 3. Clinical record #9, 2/28/12-4/27/12, evide that references a soci "Patient contacted an helping himc{sic} situated and hel | SERVICES" states, "4. The se is responsible for the essional coordination of all . d. Maintaining channels of een / among all active nents same on patient / duling and participation in with a certification period of 7/14/12-9/11/12, evidenced a 1300 that references a social nt titled "Patient states, "I called her and Evaluation and send the I the Social Worker with the eas signed by the director of record failed to evidence or other information worker, the name of the the agency coordinated the orker. with a certification period of enced a note dated 4/18/12 all worker. The note states, d said the social worker is | G | 143 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | LTIPLE CONSTRUCTION | ON | (X3) DATE S COMPL | |
|--------------------------|--|---|---------------------|---|--|----------------------|----------------------------|
| | | 012649 | B. WING | S | | 08 | /03/2012 |
| | COVIDER OR SUPPLIER | | • | STREET ADDRESS, C 8727 COMMERCE INDIANAPOLIS, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH | ROVIDER'S PLAN OF CORF H CORRECTIVE ACTION S S-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| G 143 | Social worker informed The clinical record faithe social worker and | ed and patient released." led to evidence the name of the outcome of the | G ² | 43 | | | |
| G 144 | communication with A 484.14(g) COORDIN SERVICES | | G ² | 44 | | | |
| | | minutes of case n that effective interchange, nation of patient care does | | | | | |
| | Based on clinical rec review, the agency fa of care occurred with services for 2 of 2 (# reviewed of patients r | not met as evidenced by: ord review and policy iled to ensure coordination other entities providing 2 and 9) patient records receiving services from other ntial to affect all patients m another entity. | | | | | |
| | Findings include: | | | | | | |
| | staff professional nurs following: a. The profe home care services communication betwee caregivers and docum | SERVICES" states, "4. The se is responsible for the essional coordination of all . d. Maintaining channels of | | | | | |
| | 5/15/12-7/13/12 and | with a certification period of 7/14/12-9/11/12, evidenced a 1300 that references a social | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | | • | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 144 | she clarified only RN report to MD, and cal findings." The note we nursing. The clinical any communication or egarding the social worker, or that care with the social was care with the social worker, or that care with the social worker, or that care with the social worker, or that care with the social worker as communication and has call worker social worker word) medicine stole the Adult Protective Strug person and may Adult)" A discharge states, "Unmet Goals home and has no hor 04/28/12. Said when Social worker informed | nt titled "Patient states, "I called her and Evaluation and send the I the Social Worker with the as signed by the director of record failed to evidence or other information worker, the name of the the agency coordinated the worker. With a certification period of enced a note dated 4/18/12 ial worker. The note states, d said the social worker is ated" 2 at 12:15 states, "Social Wishard - may (illegible on (illegible word) Report to be selling drugs (327-1403 summary dated 6/28/12 : Patient not situated at the where we can visit from the gets a home will call. and and patient released." led to evidence the name of the outcome of the APS. | | 151 | | | |
| | This CONDITION is | not met as evidenced by: | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | VIDER OR SUPPLIER | ; | | 87 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 152 F | etermined the agency rofessional advisory urse for 1 of 1 agency agency policy ischarge, medical submergency care, clinicy and program evaluation otential to affect all the foliation of the compact o | review and interview, it was by failed to ensure a group included a registered by with the potential to affect and (See G 152), failed to advisory group had met to be for admission and apervision and plans of care, cal records, qualifications on for 1 of 1 agency with the he agency's patients (See G sure the group of all met frequently for 1 of 1 atial to affect all the agency's inability to meet the condition of Participation advisory Group. ROFESSIONAL all personnel includes at and one registered nurse ealth nurse), and ation from other | | 151 | | | |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | | E CONSTRUCTION | (X3) DATE SUR COMPLETE | |
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| | | 012649 | B. WIN | G | | 08/03 | 3/2012 |
| | GRACE MY CHOICE IN | 3 | | 872 | EET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| G 152 | identified 2 people we Advisory Committee. were doctors. No off being on the Commit 2. Review of agency evidence any minutes professional advisory 3. On 7/31/12 at 1:25 director of nursing ind Advisory Committee waiting for the Medica 484.16 GROUP OF PERSONNEL The group of profess and annually reviews governing scope of s and discharge policies plans of care, emerge personnel qualification At least one member owner nor an employ This STANDARD is Based on document interview, the agency professional advisory agency policies for a medical supervision a emergency care, clin and program evaluation. | ated Organization Chart ere on the Professional Both of the people listed her names were identified as tee. documents failed to s for meetings of the r committee. 5 PM, the administrator / dicated the Professional had not met as they were aid Certification Survey. PROFESSIONAL ional personnel establishes the agency's policies ervices offered, admission es, medical supervision and ency care, clinical records, ens, and program evaluation. of the group is neither an ere of the agency. not met as evidenced by: review, policy review, and r failed to ensure a r group had met to establish dmission and discharge, | | 152 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | E CONSTRUCTION | (X3) DATE SUR COMPLETI | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | OVIDER OR SUPPLIER | | · | 872 | ET ADDRESS, CITY, STATE, ZIP CODE 17 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 153 | Continued From page | 25 | G | 153 | | | |
| G 154 | the group had met to 2. The undated policy PROFESSIONAL AD's states, "Meetings: The meet at least twice yet COMMITTEE DUTIES review the Agency po services offered, adm policies, medical supe treatment, emergency personnel qualification 3. On 8/3/12 at 4:20 F indicated there had be meetings. 484.16(a) ADVISORY FUNCTION The group of professi frequently to advise th issues, to participate agency's program, an maintaining liaison wi | s for meetings of the committee that indicated establish agency policies. y titled "1.15 VISORY COMMITTEE" e Advisory Committee shall early. ADVISORY S: 1. Establish and annually licies governing the scope of dission and discharge ervision and plans of y care, clinical records, and ens." PM, the director of nurses een no professional advisory Y AND EVALUATION onal personnel meets the agency on professional in the evaluation of the did to assist the agency in the other health care munity and in the agency's | G | 154 | | | |
| | Based on document | not met as evidenced by: review and interview, the re the group of professional | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | PLE CONSTRUCTION | (X3) DATE SUR COMPLETE | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
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| G 154 | the potential to affect Findings: 1. Review of agency evidence any minutes professional advisory 2. On 7/31/12 at 1:25 director of nursing ind Advisory Committee waiting for the Medica | ently for 1 of 1 agency with all the agency's patients. documents failed to so for meetings of the | | 154 | | | |
| | Based on document review, observation, it was determined the needs of the patients adequately met in the for 1 of 12 clinical receptantial to affect all to (See G 157), failed to provided to the patiencare and care was provided to the plan of care (See the plan of care contawas signed by the phreviewed with the pot patients of the agence. | | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONSTRUCTION | (X3) DATE SUR\ COMPLETE | |
|--------------------------|--|--|---------------------|------|---|-------------------------|----------------------------|
| | | 012649 | B. WING | | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER | I | | 8727 | T ADDRESS, CITY, STATE, ZIP CODE COMMERCE PARK PL STE L IANAPOLIS, IN 46268 | | 3/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| G 156 | Participation 484.18: Plan of Care, and Me | red by the Condition of Acceptance of Patients, | G 1 | | | | |
| | Patients are accepted of a reasonable expemedical, nursing, and | d for treatment on the basis ctation that the patient's I social needs can be met ency in the patient's place of | | | | | |
| | Based on clinical red and interview, the ago needs of the patients adequately met in the for 1 of 12 (#9) clinical | not met as evidenced by: cord review, policy review, ency failed to ensure the accepted for care could be e patient's place of residence al records reviewed with the the patient's of the agency. | | | | | |
| | Findings include: | | | | | | |
| | 2/8/12-4/27/12, evide dated 4/2/12 that stat able to tidy, keep clea Dr. I am making a rec hrs of personal care s | with a certification period of enced a FAX COVER SHEET es,"COMMENTS: He is not an with his current diagnosis quest that you allow him 5 service to assist in meals are note was signed by the or of nursing. | | | | | |
| | "Patient needs persol living and house main | dated 4/3/12 states, nal care for activities of daily ntenance." The clinical nce the personal care was | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | PLE CONSTRUCTION | (X3) DATE SUR COMPLETI | |
|--------------------------|--|--|-------------------|-----|--|---------------------------|----------------------------|
| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | COVIDER OR SUPPLIER | 3 | • | 87 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| G 157 | GUIDELINES" states requiring other therap provided by the Agen services than we can assessment by the readmitted." 3. On 7/31/12 at 5:00 indicated she is not p director of nursing stathe nurse and the hor 484.18 ACCEPTANO MED SUPER Care follows a writter | titled "2.26 PATIENT CARE , "1. Patients / clients peutic services which are not cy, or a greater intensity of provide based on the initial egistered nurse, will not be D. PM, the director of nursing roviding all services. The ated, "I do everything. I am me health aide." TE OF PATIENTS, POC, In plan of care established wed by a doctor of medicine, | | 157 | | | |
| | Based on clinical recompolicy review, the age medical care provided on the plan of care are ordered on the plan of records reviewed (#2 affect all the patients Findings include: 1. Clinical record #2, included plans of care physician for certifica 7/13/12 and 7/14/12 notes evidenced that were performed by the | -8) with the potential to of the agency. start of care 5/15/12, e established by the | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | 2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED SUILDING | | | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | • | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| G 158 | 7/18/12, 7/17/12 and failed to evidence any oximetry/O2 sats. On 7/6/12, the skille insulin was administe were prefilled by the r 7/2012, the skilled nu syringes were prefille. The plan of care failed the insulin administratinsulin syringes. 2. Clinical record #3, included plans of care physician for certificat 7/21/12 and 7/22/12 notes evidenced that the registered nurse of 6/1/12, 6/4/12, 6/8/12, 7/10/12, 7/17/12, and 7/20/12. clinical record failed to orders for pulse oxime. A. During the home the director of nursing pulse oximetry on the B. The skilled nurse box for next 7 days" of 7/13/12, and 7/17/12. evidence any orders for are certification periods 5 | d nurse note evidenced red and insulin syringes registered nurse. On ree note evidenced insulin d by the registered nurse. d to evidence any orders for tion and prefill of the of start of care 1/24/12, e established by the tion periods 5/23/12 - 9/19/12. The skilled nurse O2 sats were performed by on 5/21/12, 5/25/12, 5/28/12, 6/11/12, 6/22/12, 6/26/12, The plans of care and o evidence any physician etry/O2 sats. Visit on 8/1/12 at 11:20 AM, a was observed to perform a patient. Inote states, "Refilled med on 6/4/12, 6/11/12, 7/10/12, The plan of care failed to to fill medication box. | G | 158 | | | |

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|---|---|-----------------------------|---|----------------------|----------------------------|
| | | 012649 | B. WING | | 08 | /03/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE IN | С | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | , « | 70072012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| G 158 | director of nursing inmultiple attempts to chad not been able to patient's mother was physician to provide B. A "FAX COVER administrator / direct states, "COMMENTS would like you to know is not being billed by other MD to contact appreciate if you cout [indicates patient's not hazing Grace MC." indicate the fax was a 7/13/12, and 7/14/12 The record evides services since the state were no physician or C. The skilled nurs box for next 7 days failed to evidence and 4. Clinical record #5, included plans of car certification periods \$1.9/9/12. The plan of 5/14/12 - 7/13/12 had health aide] 8 hrs tim times 5 days times 8 | dicated she had made contact the physician and get orders and the mother trying to find another care for the patient. SHEET' signed by the cor of nursing dated 7/9/12 cor of cortification period dorders for "HHA [home less 1 day [8 hours per day] weeks [5 days a week for 8 cortical corders were | G 158 | | | |

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| (X5) COMPLETION DATE |
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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | LTIPLE CONSTF DING | RUCTION | (X3) DATE SU COMPLE | | |
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| | | 012649 | B. WINC | ; | | 08/ | 03/2012 | |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE IN | С | | 8727 COMM | ESS, CITY, STATE, ZIP CODE IERCE PARK PL STE L OLIS, IN 46268 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE APP DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE | |
| G 158 | 7/14/12 and 7/13/12 notes evidenced that the registered nurse and clinical record far physician orders for A. The skilled nurse box for next 7 days" 7/13/12, and 7/27/12 evidence any orders 6. Clinical record #7, included plans of car physician for the cert 7/12/12 and 7/13/12 notes evidenced that the registered nurse and 7/9/12. The plan any physician orders 7. Clinical record #8, plans of care establis certification periods 9/2/12. The skilled in O2 sats were perforr on 6/5/12, 6/8/12, 6/2 7/13/12, 7/17/12, 7/2 of care failed to evide O2 sats. A. The recertification with the date assess documented under E Gloves: sterile Oth necessary." The plan | ification periods 5/15/12 9/10/12. The skilled nurse c O2 sats were performed by on 6/4/12. The plans of care iled to evidence any oulse oximetry/O2 sats. e note stated, "Refilled med on 6/4/12, 6/12/12, 6/26/12, . The plans of care failed to to fill medication box. start of care 3/15/12, e established by the ification periods 5/14/12 9/10/12. The skilled nurse c O2 sats were performed by on 6/19/12, 6/26/12, 7/6/12, s of care failed to evidence | G 1 | 58 | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU | | LE CONSTRUCTION | (X3) DATE SUF | |
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| | | 040040 | B. WIN | | | | |
| NAME OF PR | OVIDER OR SUPPLIER | 012649 | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | 08/0 | 3/2012 |
| AMAZING | GRACE MY CHOICE INC | 3 | | | 27 COMMERCE PARK PL STE L | | |
| (VA) ID | SHMMARY ST | ATEMENT OF DEFICIENCIES | ID | IN | PROVIDER'S PLAN OF CORRECT | ION . | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | x | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 158 | Continued From page | e 33 | G | 158 | | | |
| | the director of nursing on the patient and the | visit on 8/2/12 at 12:30 PM, g performed pulse oximetry e patient showed the director rveyor her Port located on | | | | | |
| | RECORDS CONTEN Orders b. Physicial following: (4) Medic Change of Physician' orders that occur before are to be documented written request is to be in writing. These orde physician within 30 da Care Plan a. Each pa a Home Health Aide i developed by the coo of service. It is to be to | r titled "2.57 CLINICAL ITS" states, "3. Physician's n's orders are to cover the cations (5) Treatment 4. s Orders a. Changes in ore the orders are renewed d in the clinical record and a se sent to obtain the orders ers are to be signed by the ays 6. Home Health Aide titlent receiving service from s to have a care plan ordinating nurse at the onset updated as needed and at or patients receiving skilled | | | | | |
| G 159 | CRITERIA" states, "4 skilled services must physician. The physic include orders for all | | G | 159 | | | |
| | The plan of care deve the agency staff cove including mental statu equipment required, f | eloped in consultation with rs all pertinent diagnoses, us, types of services and | | | | | |

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| | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | PLE CONSTRUCTION | (X3) DATE SUR COMPLETI | |
|--------------------------|---|---|--------------------|-----|---|---------------------------|----------------------------|
| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | · | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 159 | safety measures to prinstructions for timely any other appropriate | permitted, nutritional autions and treatments, any rotect against injury, discharge or referral, and items. | G | 159 | | | |
| | Based on clinical rec and interview, the age plan of care contained signed by the physicia 9, 10, 11, and 12) rec | not met as evidenced by: ord review, policy review, ency failed to ensure the d the medications and was an for 9 of 12 (#1, 2, 3, 4, 8, ords reviewed with the he patients of the agency. | | | | | |
| | Findings: | | | | | | |
| | the certification period failed to evidence the The document states. The clinical record fai | ncluded a plan of care for d 1/11/12 - 3/10/12 that patient had medications. "See attached med sheet" led to evidence the s attached to the plan of | | | | | |
| | certification periods 5 - 9/11/12 that failed to medications. The plan 7/13/12 states, "See pare for 7/14/12 - 9/12 attached med profile" evidence the medicate the plan of care. 3. Clinical record #3 in the certification period. | ncluded plans of care for the /15/12 -7/13/12 and 7/14/12 of evidence the patient had in of care for 5/15/12 - pages attached." The plan of 1/12 states, "Please see The clinical record failed to ion records were included in included plans of care for its 5/23/12 - 7/21/12 and failed to evidence the | | | | | |

| | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | PLE CONSTRUCTION | (X3) DATE SUR COMPLETE | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 159 | 5/23/12 - 7/21/12 state plan of care for 7/22/1 next page." The clinic the medication record care. 4. Clinical record #4 in certification periods 5 - 9/9/12 that failed to medications. The plan 7/11/12 states, "NA." - 9/9/12 is blank in are of care failed to evide medications. A. The skilled nurse 6/18/12, signed by the "no change." The line states, "Melonex prn plan of care did not in B. The plans of care physician. C. On 8/2/2012 at 4: director of nursing ind multiple attempts to chad not been able to the patient was trying provide care for the p 5. Clinical record #8 in certification periods 5 9/2/12 that failed to emedications. The plan plan of the patient was trying provide care for the patient was trying provide care for the p | ns. The plan of care for es, "As per MD order." The 12 - 9/19/12 states, "Behind cal record failed to evidence I was included in the plan of included plans of care for the 1/3/12 - 7/11/12 and 7/12/12 evidence the patient had in of care for 5/13/12 - The plan of care for 7/12/12 ea for medications. The plan ince if the patient had any ince if the patient had and ince if the patient had included plans of care for the include | G | 159 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 | |
| | COVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 159 | medications." The cli evidence the medicat the plan of care. 6. Clinical record #9 in the certification period failed to evidence the The plan of care state The clinical record fai medication record wa care. 7. Clinical record #10 the certification period failed to evidence the The plan of care state medication profile." T evidence the medicat the plan of care. 8. Clinical record #11 the certification period to evidence the patier of care states, "See in clinical record failed to record was included in 9. The undated policy RESPONSIBILITIES" notify the physician el writing or fax of the pa including but not limite Medications are ineffe adverse reactions, sig present, drug allergy contraindicated medic confusion on medicat | nical record failed to ion record was included in included a plan of care for d 2/28/12 - 4/27/12 that patient had medications. It is, "See medication profile." led to evidence the s included in the plan of included a plan of care for d 4/15/12 - 6/30/12 that patient had medications. It is, "See attached in included a plan of care for d 9/30/11-11/7/11 that failed in thad medications. The plan included a plan of care for d 9/30/11-11/7/11 that failed in thad medications. The plan included in the plan of care. If titled "2.20 PHYSICIAN states, "12. The Agency will ther verbally and/or in attent / client's condition indicates gnificant side effects are | G | 159 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MU A. BUIL | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--------|--|---|---|--------|
| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTI TAG CROSS-REFERENCI | | N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY) | |
| G 159 | patient / client clinical communication form form." 10. On 7/31/12 at 4:3 director of nursing income. | on is maintained in the I record on either a or a verbal / telephone order O PM, the administrator / dicated there was no dence the physician had | G | 159 | | | |
| G 170 | This STANDARD is reposed on clinical recordered on the plan of provided only as ordered of 7 active records repotential to affect all the Findings include: 1. Clinical record #2, included plans of care physician for certificate 7/13/12 and 7/14/12 | killed nursing services in plan of care. not met as evidenced by: cord review, observation, and ency failed to ensure the vided medical care as of care and care was ered on the plan of care in 7 viewed (#2-8) with the the patients of the agency. | | 170 | | | |
| | 6/2/12, 6/14/12, 6/28/ 7/18/12, 7/17/12 and | ne registered nurse on 1/12, 7/3/12, 7/6/12, 7/11/12, 7/24/12. The plans of care y physician orders for pulse | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | 3 | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER | С | | 8727 | CADDRESS, CITY, STATE, ZIP CODE COMMERCE PARK PL STE L ANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTIO | | N SHOULD BE COMPLETION DATE | |
| G 170 | On 7/6/12, the skilled insulin was administed were prefilled by the 7/2012, the skilled not syringes were prefilled. The plan of care failed the insulin administratinsulin syringes. 2. Clinical record #3, included plans of care physician for certification for cer | ed nurse note evidenced ered and insulin syringes registered nurse. On urse note evidenced insulin ed by the registered nurse. Ed to evidence any orders for ation and prefill of the of estate of care 1/24/12, e established by the etion periods 5/23/12 9/19/12. The skilled nurse 1/24/12, 5/25/12, 5/28/12, 2, 6/11/12, 6/22/12, 6/26/12, e. The plans of care and to evidence any physician etry/O2 sats. Visit on 8/1/12 at 11:20 AM, g was observed to perform e patient. E note states, "Refilled med on 6/4/12, 6/11/12, 7/10/12, . The plan of care failed to to fill medication box. start of care 3/14/12, | G | 170 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED | | | | | | | |
|---|---|---|--------------------|-----|---|--------|----------------------------|
| | | 012649 | B. WING | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER | | | 872 | ET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | , 00/0 | <i></i> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 170 | multiple attempts to contact had not been able to patient's mother was physician to provide of the states, "COVER administrator / directors states, "COMMENTS would like you to know is not being billed by other MD to contact for appreciate if you coul [indicates patient's nat Amazing Grace MC." indicate the fax was so the state were no physician or contact for next 7 days" of ailed to evidence and 4. Clinical record #5, included plans of care certification periods 5-9/9/12. The skilled med box times 7 days 6/26/12, and 7/27/12. evidence any orders of the clinical record Profile" updated 6/12, 7/13/12, and 7/20/12 | ontact the physician and get orders and the mother trying to find another care for the patient. SHEET' signed by the or of nursing dated 7/9/12 Dr. [the physician's name] I wat the moment this patient our Agency. We have no or her apart from you. We dign this [sic] orders for ame] to get help from Document notations sent on 4/12/12, 5/13/12, Inced the patient received art of care on 3/14/12. There ders for any of this care. In note stated, "Refilled med on 6/5/12. The plan of care order for this. In start of care 3/14/15, the established for the care of 6/12/12 and 7/12/12 or order for the stated, "Refilled so on 6/12/12, 6/22/12, The plan of care failed to | G. | 170 | | | |

| NAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | STATEMENT OF DEFICIENCIES (X1) PROVIDE IDENTIFIC | |
|---|--|--|
| AMAZING GRACE MY CHOICE INC 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | PREFIX (EACH | |
| G 170 Continued From page 40 5. Clinical record #6, start of care 3/15/12, included plans of care established by the physician for the certification periods 5/15/12 - 7/14/12 and 7/13/12 - 9/10/12. The skilled nurse notes evidenced that O2 sats were performed by the registered nurse on 6/4/12. The plans of care and clinical record failed to evidence any physician orders for pulse oximetry/O2 sats. A. The skilled nurse note stated, "Refilled med box for next 7 days" on 6/4/12, 6/12/12, 6/26/12, 7/13/12, and 7/27/12. The plans of care failed to evidence any orders to fill medication box. 6. Clinical record #7, start of care 3/15/12, included plans of care established by the physician for the certification periods 5/4/14/12 - 7/12/12 and 7/13/12 - 9/10/12. The skilled nurse notes evidenced that O2 sats were performed by the registered nurse on 6/19/12, 6/26/12, 7/6/12, and 7/9/12. The plans of care failed to evidence any physician orders for O2 sats. 7. Clinical record #8, start of care 9/9/11, included plans of care established by the physician for the certification periods 5/6/12 - 7/5/12 and 7/5/12 - 9/2/12. The skilled nurse notes evidenced that O2 sats were performed by the physician for the certification periods 5/6/12 - 7/5/12 and 7/5/12 - 9/2/12. The skilled nurse notes evidenced that O2 sats were performed by the registered nurse on 6/5/12, 6/8/12, 7/3/12, 7/13/12, | 5. Clinical re included plan physician for 7/14/12 and notes evider the registere and clinical re physician ord. A. The skill box for next 7/13/12, and evidence any 6. Clinical re included plan physician for 7/12/12 and notes evider the registere and 7/9/12. any physician 7. Clinical re plans of care certification physician for 2/12. The O2 sats were on 6/5/12, 6/7/13/12, 7/13 of care failed O2 sats. A. The re with the date documented | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| G 170 | failed to evidence any Port cath. B. During the home the director of nursing on the patient and the of nursing and the su her right upper chest. 8. The undated policy RECORDS CONTEN Orders b. Physicial following: (4) Medic Change of Physician' orders that occur before are to be documented written request is to be in writing. These order physician within 30 dc Care Plan a. Each para a Home Health Aide in developed by the coordinated services. It is to be used to be considered by the coordinated policy CRITERIA" states, "4 skilled services must physician. The physician clude orders for all chore, or sitter service required by the state. | s of care and clinical record y physician orders for the visit on 8/2/12 at 12:30 PM, g performed pulse oximetry e patient showed the director recyor her Port located on vitiled "2.57 CLINICAL ITS" states, "3. Physician's n's orders are to cover the cations (5) Treatment 4. s Orders a. Changes in ore the orders are renewed d in the clinical record and a resent to obtain the orders ers are to be signed by the lays 6. Home Health Aide tient receiving service from s to have a care plan ordinating nurse at the onset updated as needed and at or patients receiving skilled vitiled "2.13 ELIGIBILITY". Patients / clients needing be under the care of a cian's plan of treatment shall services except household, es unless such orders are " | | 170 | | | |
| G 171 | 484.30(a) DUTIES O NURSE The registered nurse | makes the initial evaluation | | ., 1 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|-----------------------------------|--|-------------------------------|--------|
| | | 012649 | B. WING | | | 08/0 | 3/2012 |
| | COVIDER OR SUPPLIER | 3 | | 872 | ET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | 1 00/0 | 0/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | PREFIX (EACH CORRECTIVE ACTION SI | | OULD BE COMPLETION | |
| G 171 | Continued From page visit. | e 42 | G · | 171 | | | |
| | Based on clinical recinterview, the agency registered nurse comvisit within 48 hours or records reviewed (#9 all new patients of the Findings include: 1. Clinical record #9, was referred for home assessment visit was The clinical record evithe administrator / dir " 02/24/12 11 AM, [the referred from [the narthrough the social wowas made to [the nanassessment and administrator who answered 3:30 PM The Social Whospital] called and cand made an appoint 2/28/12 9 am. A visit assessment." 2. The undated policy FOR ASSESSMENT ASSESSMENT state will be made within 48 3. On 7/31/12 at 1:10 conference the administration of the conference the conference the administration of the conference the conference the conference of the conference the conference of the conference of the conference the conference of the confere | pleted an initial assessment of referral of 1 of 12 patient owith the potential to affect | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DATE S COMPLE | |
|---|---|--|----------------------|--|------------------------------|----------------------------|
| | | 042640 | B. WING | | | |
| | COVIDER OR SUPPLIER | 012649 | | STREET ADDRESS, CITY, STATE, ZIP CODE 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | l l | /03/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| G 171 G 176 | 484.30(a) DUTIES O NURSE The registered nurse progress notes, coord | s the patient declines. F THE REGISTERED prepares clinical and dinates services, informs the ersonnel of changes in the | G 1° | | | |
| | Based on clinical recreview, the agency far nurse coordinated with services for 2 of 2 (#reviewed of patients in | not met as evidenced by: ord review and policy iled to ensure the registered th other entities providing 2 and 9) patient records receiving services from other otial to affect all patients m another entity. | | | | |
| | 1. The undated policy COORDINATION OF staff professional nurs following: a. The profineme care services communication betwee caregivers and docur | SERVICES" states, "4. The se is responsible for the essional coordination of all . d. Maintaining channels of | | | | |
| | 5/15/12-7/13/12 and note dated 5/9/12 at worker. The docume Communication Log" she clarified only RN | with a certification period of 7/14/12-9/11/12, evidenced a 1300 that references a social nt titled "Patient states, "I called her and Evaluation and send the I the Social Worker with the | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| G 176 | findings." The note we nursing. The clinical any communication or regarding the social we social worker, or that care with the social we 3. Clinical record #9, 2/28/12-4/27/12, evid that references a soc "Patient contacted and helping himc{sic} situ. A note dated 5/10/12 worker social worker word) medicine stole the Adult Protective Sidrug person and may Adult)" A discharge states, "Unmet Goals home and has no hor 04/28/12. Said when Social worker informed The clinical record faithe social worker and communication with Associal worker and communication with Association | as signed by the director of record failed to evidence or other information worker, the name of the the agency coordinated the worker. with a certification period of denced a note dated 4/18/12 dial worker. The note states, and said the social worker is ated" 2 at 12:15 states, "Social of Wishard - may (illegible en (illegible word) Report to Services (APS). He may be a wide selling drugs (327-1403 summary dated 6/28/12 states): Patient not situated at the where we can visit from the gets a home will call. The outcome of the APS. | | 202 | | | |
| | Based on personnel and interview, it was to ensure the home h competency evaluation health files reviewed the patients receiving | not met as evidenced by: file review, policy review, determined the agency failed health aide had completed a non program for 1 of 2 home with the potential to affect all home health aide services. 2), failed to ensure the | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 872 | ET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY) | | SHOULD BE COMPLETION | |
| G 202 | areas listed at paragrof this section for 1 or reviewed with the pot patients receiving hor G 213), the agency fahealth aide had compevaluation on a patient subject areas at para and (xi) of this section files reviewed (See G documentation evide had completed a comprior to providing serviewed section of the section of the section files reviewed (See G documentation evide had completed a comprior to providing serviewed section files reviewed (See G documentation evide had completed a comprior to providing serviewed section for the section files are serviced for the section for the sec | inpetency evaluation all of the required subjects aphs (a)(1)(ii) through (xiii) f 2 home health aides ential to affect all the me health aide services (See ailed to ensure the home bleted a competency int or pseudo patient in the graphs (a)(1) (iii) (ix), (x), in for 1 of 2 home health aide is 218), and failed to ensure inced the home health aide inpetency evaluation program vices for 1 of 2 home health al to affect all the patients of | G | 202 | | | |
| G 211 | resulted in the agenchome health aide carby the Condition of PHealth Aide services. 484.36(b)(1) COMPEIN-SERVICE TRAI An individual may fur services on behalf of individual has succescompetency evaluation this paragraph. This STANDARD is a Based on personnel and interview, the agence is the service of the services | TENCY EVALUATION & nish home health aide an HHA only after that | G | 2211 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | OVIDER OR SUPPLIER | | • | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| G 211 | reviewed with the pot patients receiving hor Findings include: 1. Personnel file D, da evidence the aide had evaluation program. first patient contact. 2. On 8/3/12 at 2:15 F director of nursing incompetency evaluation. 3. The undated policy RECORDS" states, "2 qualifications for the otraining for all client of training for all client of the following: a. Consumption of the following: a. Co | or 1 of 2 home health files ential to affect all the me health aide services. (D) ate of hire 2.24/12, failed to d completed a competency. The file failed to evidence a PM, the administrator / licated there was no on for employee D. Attitled "PERSONNEL 2. Verifications of duties and certificate of are workers." Attitled "4.49 HOME HEALTH COMPETENCY" states, "1. and Personal Care Worker all demonstrate competence emonstrated by one or more ompletion of an approved 75 a.b. On-site observation of gency shall be responsible using and testing procedures ovide the preparation of successfully pass a on or use only Aides who utalifications for "Home cified in section 484.4 of the | | 211 | | | |
| G 212 | 484.36(b)(1) COMPE IN-SERVICE TRAI | TENCY EVALUATION & | G | 212 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SULTAND PLAN OF CORRECTION (IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SULTAND COMPLET | | | | | | | |
|--|---|--|--------------------|-----|--|---------|---|
| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | COVIDER OR SUPPLIER | 3 | | 8 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | 1 00/00 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| G 212 | The HHA is responsition its behalf meet the requirements of this set. This STANDARD is a | ole for ensuring that the sh home health aide services competency evaluation | G | 212 | | | |
| | home health aide had evaluation program for reviewed with the pot patients receiving home | ency failed to ensure the d completed a competency or 1 of 2 home health files ential to affect all the me health aide services. (D) | | | | | |
| | evidence the aide had | ate of hire 2.24/12, failed to d completed a competency The file failed to evidence a | | | | | |
| | director of nursing incompetency evaluation. 3. The undated policy RECORDS" states, "2007. | on for employee D. / titled "PERSONNEL | | | | | |
| | 4. The undated policy AIDE TESTING AND Each Home Health ai (together, "Aides") sh for their position as dof the following: a. Cohour training program | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE | |
| G 212 | for implementing train for Aides and must prinecessary for aides to competency evaluation meet the personnel que | ing and testing procedures ovide the preparation | G2 | 212 | | | | |
| G 213 | IN-SERVICE TRAI The competency eval | PETENCY EVALUATION & uation must address each of paragraphs (a)(1)(ii) through | G2 | 213 | | | | |
| | Based on personnel interview the agency is health aide competen addressed all of the reat paragraphs (a)(1)(i | e health aides reviewed (D) ffect all the patients | | | | | | |
| | Findings include: | | | | | | | |
| | evidence the aide had | ate of hire 2.24/12, failed to discompleted a competency. The file failed to evidence a | | | | | | |
| | 2. On 8/3/12 at 2:15 F director of nursing ind competency evaluation | | | | | | | |
| | 3. The undated policy | titled "PERSONNEL | | | | | | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | LTIPLE CONSTRUCTION DING | ` ' | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WING | ; | 08/0 | 3/2012 | |
| | COVIDER OR SUPPLIER | 2 | | STREET ADDRESS, CITY, STATE, ZIP CODE 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| G 213 | training for all client c 4. The undated policy AIDE TESTING AND Each Home Health ar (together, "Aides") sh for their position as do of the following: a. Co hour training program competency 2. The A for implementing train for Aides and must processary for aides to competency evaluation meet the personnel q | 2. Verifications of duties and certificate of fare workers." / titled "4.49 HOME HEALTH COMPETENCY" states, "1. and Personal Care Worker stall demonstrate competence emonstrated by one or more completion of an approved 75 and b. On-site observation of agency shall be responsible being and testing procedures revide the preparation | G 2 | 13 | | | |
| G 218 | IN-SERVICE TRAI The subject areas list (ix), (x), and (xi) of thi after observation of the tasks with a patient. paragraph (a)(1) of the through written examinater observation of a patient. This STANDARD is real Based on personnel agency failed to ensu completed a competer. | ted at paragraphs (a)(1)(iii), is section must be evaluated the aides performance of the The other subject areas in his section may be evaluated ination, oral examination, or home health aide with a mot met as evidenced by: file review and interview, the are the home health aide had ency evaluation on a patient the subject areas listed at | G 2 | 118 | | | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------|---|--|-------------------------------|----------------------------|
| | | 012649 | B. WING | | | 08/03/2012 | |
| | OVIDER OR SUPPLIER | | • | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | , , , , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| G 218 | paragraphs (a)(1) (iii) section for 1 (File D) or reviewed. Findings include: 1. Personnel file D, da evidence the aide had evaluation program. first patient contact. 2. On 8/3/12 at 2:15 File director of nursing incompetency evaluation. 3. The undated policy RECORDS" states, "2 qualifications for the or training for all client or training for all client or the following: a. Cohour training program competency 2. The Afor implementing train for Aides and must pronecessary for aides to competency evaluation meet the personnel qualifications of the proposed to the following: a. Cohour training program competency 2. The Afor implementing train for Aides and must pronecessary for aides to competency evaluation meet the personnel qualifications. | ate of hire 2.24/12, failed to d completed a competency. The file failed to evidence a completed there was no on for employee D. It titled "PERSONNEL 2. Verifications of duties and certificate of are workers." It titled "4.49 HOME HEALTH COMPETENCY" states, "1. and Personal Care Worker all demonstrated by one or more employee of an approved 75 b. On-site observation of gency shall be responsible using and testing procedures ovide the preparation | G | 218 | | | |
| G 221 | _ | TENCY EVALUATION & | G | 221 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------|---|---|--------|-------------------------------|--|
| | | 012649 | B. WIN | G | | 08/0 | 3/2012 | |
| | ROVIDER OR SUPPLIER | | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | , 00/0 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE | |
| G 221 | demonstrates that the standard are met. This STANDARD is a Based on personnel and interview the age documentation evided had completed a comprior to providing servaides (D) with the post patients of the agence. Findings include: Based on personnel a finterview, the agency health aide had completed a compevaluation program for reviewed with the post patients receiving hor patients receiving hor Findings include: 1. Personnel file D, devidence the aide had evaluation program. first patient contact. 2. On 8/3/12 at 2:15 findirector of nursing incompetency evaluation. 3. The undated policy RECORDS" states, "2000 and interview." | ain documentation which a requirements of this entered by: record review, policy review ency failed to ensure enced the home health aide expetency evaluation program vices for 1 of 2 home health ential to affect all the e | G | 221 | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WING | | | |
| NAME OF PR | OVIDER OR SUPPLIER | 012049 | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 08/0 | 3/2012 |
| AMAZING | GRACE MY CHOICE IN | | | 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| G 221 | AIDE TESTING AND Each Home Health a (together, "Aides") sh for their position as d of the following: a. Co hour training program competency 2. The A for implementing trair for Aides and must processary for aides to competency evaluation meet the personnel question. | r titled "4.49 HOME HEALTH COMPETENCY" states, "1. and Personal Care Worker all demonstrate competence emonstrated by one or more empletion of an approved 75 a.b. On-site observation of gency shall be responsible ning and testing procedures rovide the preparation of successfully pass a on or use only Aides who ualifications for "Home cified in section 484.4 of the | G 22 | | | |
| | Based on clinical recreview, policy review, determined the agent names were accurate and errors were identical records review affect all the agency's to ensure there was a retention of clinical rerequired by IC 16-39-with the potential to a patients (See G 237), records were secured 1 agency with the potentials (See G 237). The cumulative effects | cy failed to ensure dates and e, documents were legible, iffied by initials in 7 of 12 wed with the potential to a patients (See G 236); failed a policy to provide for the ecords for a period of time e.7 (7 years) in 1 of 1 agency ffect all the agency's and failed to ensure clinical of from potential theft for 1 of tential to affect all the | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ILTIPLE | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WING | | | 00/0 | 3/2012 |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | L | | 872 | ET ADDRESS, CITY, STATE, ZIP CODE 17 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | <u> </u> 06/0: | 5/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 235 G 236 | Continued From page requirements of the C 484.48 Clinical Recor 484.48 CLINICAL RE | condition of Participation ds. | G 2 | | | | |
| | current findings in acc professional standard patient receiving hom addition to the plan of appropriate identifying physician; drug, dieta orders; signed and da notes; copies of sumr | aining pertinent past and cordance with accepted ls is maintained for every se health services. In a f care, the record contains g information; name of ry, treatment, and activity ated clinical and progress mary reports sent to the and a discharge summary. | | | | | |
| | Based on clinical rec and interview, the age and names were accu legible and errors were 12 clinical records rev | not met as evidenced by: ord review, policy review, ency failed to ensure dates urate and documents were re identified by initials in 7 of viewed (#1, 2, 3, 5, 7, 8, and I to affect all the patients of | | | | | |
| | Findings include: | | | | | | |
| | period 1/11/12-3/10/1 | are with a certification 2 with the physician's name not the same name as the | | | | | |
| | first document states, | start of care 5/15/12, admission documents. The "Today's date 5/10/12." ed by the registered nurse | | | | | |

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| | EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|--|---|-------------------|----------------------------|--|-------|----------------------------|
| | | 012649 | B. WIN | G | · · · · · · · · · · · · · · · · · · · | 08/0 | 3/2012 |
| | ROVIDER OR SUPPLIER | | l | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 3727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 236 | and dated 5/9/11. The document states, "Too signed by the register 3. Clinical record #3, evidenced 2 plans of period 7/22/12-9/19/1 on 1 plan of care is proname. The first name first name printed a 2 care, for the same dasignature. The 2 signamatch. The medication admataix 10 mg was start crossed through with word / initial) and state [milligrams]." 4. Clinical record #5, evidenced a referral / states, "Today's date On the "Receiving Recrossed out with the word to the "Receiving Recrossed out with the word of the "Recei | e 2nd referral / admission day's date 5/10/12" and is sed nurse and dated 5/16/12. Start of care 1/24/12, care for the certification 2. The physician's signature rinted with the physician's is crossed through and and time. The 2nd plan of te, has a physician's atures / names do not ministration record indicates ted on 7/10/12. The Lasix is the word error (illegible es, "Start 20 mgs start of care 3/14/12, admission document that 03/ (illegible number) 2012. ferral" the date 3/14/12 is word error and initials and e) 2012. | G | 236 | | | |

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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SUF COMPLET | |
|--------------------------|--|---|---------------------|--|--------------------------|----------------------------|
| | | 012649 | B. WING | · | 08/03/2012 | |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 1727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | 1 08/0 | 3/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 236 | 8. Clinical record #10 evidenced 2 plans of period 4/15/2012 to 6 signature dated 4/18/ and the date 6/30/12 illegible number added 9. On 7/31/12 at 1:10 conference the admir indicated the clinical drawing a line throug 10. The undated and 86, states, " (8) Docuevent a documentation member involved is racross the document that the incorrect document that the incor | d out with no initials. The idded. It, start of care 4/15/12, care for the certification 1/30/12. The physician's 1/12 on 1 of the plans of care with 30 crossed out and an ed with no initial. It PM, during the entrance inistrator / director of nursing records were corrected by the the error and initialing. Unknown policy title, page mentation Errors: (a) In the on error occurs, the staff equired to draw one line ation involved being sure umentation can still be read. If the commentation should follow, when an entry is made out of ed (*) is place in the margin in which it should appear, in in the record where the end (b) the late entry is LATE ENTRY in uppercase page, date, and line of the where the entry should ion in the patient/client ine person making it along the of the entry." | G 236 | | | |
| 2 201 | Clinical records are re | etained for 5 years after the to which the records apply | | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WING | i | | 08/03/2012 | |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | | , | | CITY, STATE, ZIP CODE SE PARK PL STE L S, IN 46268 | • | |
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| G 237 | stipulates a longer pe | nediary, unless State law | G 2 | 37 | | | |
| | Based on policy reviewensure there was a pretention of clinical re | not met as evidenced by: ew, the agency failed to olicy to provide for the cords for a period of time .7 (7 years) in 1 of 1 agency ffect all the agency's | | | | | |
| G 239 | INFORMATION" state maintained for six yea completed, in the cas after the age of major litigation is completed 484.48(b) PROTECT | ENTIALITY / RELEASE OF es, "Clinical records shall be ars after the cost report is the of minors for seven years rity and for two years after H." ION OF RECORDS ation is safeguarded against | G 2 | 39 | | | |
| | Based on document interview, the agency | not met as evidenced by: and policy review and failed to ensure clinical d from potential theft for 1 of tential to affect all the | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUII | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 012649 | B. WIN | IG | | 08/0 | 3/2012 |
| | COVIDER OR SUPPLIER | | • | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON SHO | JLD BE | (X5) COMPLETION DATE |
| G 239 | Continued From page | e 57 | G | 239 | | | |
| G 242 | the administrator was the trunk of her car w clinical records were 2. On 7/31/12 at 2:10 indicated she had prestolen from the trunk 3. The undated policy Agency Use of Record Entries" states, "All clicontents thereof are contents thereof are contented from loss a / client clinical record secure manner as to client/patient data throoff site." | PM, the administrator eviously had clinical records of her car. If titled "Confidentiality / ds / Authority to Make inical records and the confidential and will be nd unauthorized use. Patient is will be maintained in a maintain the integrity of the bugh routine backups on or | G | 242 | | | |
| | Based on policy and review and interview, agency failed to ensu the ongoing evaluation for 1 of 1 agency (See there was a plan for a the extent to which the appropriate, adequate of 1 agency (See 245 a plan for the policies practices of the agency | cy are reviewed to to which they promote | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/03/2012 | |
| | OVIDER OR SUPPLIER GRACE MY CHOICE INC | 3 | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 227 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 242 | 248), failed to ensure established in writing pertinent data to assi agency with the poter served by the agency ensure there was a professionals repressionals repressionals repressionals reviewed, at active and closed clir whether established furnishing services for 250), and failed to encontinuing review of day period that the padetermine adequacy | for 1 of 1 agency (See G mechanisms were | G | 242 | | | |
| G 244 | has resulted in the accompliance with the General treatment of the agency. 484.52: Evaluation of resulting in the potent of the agency. 484.52 EVALUATION PROGRAM The evaluation consist administrative review. This STANDARD is a Based on policy and review and interview, a plan was in place for the agency's program. | Condition of Participation factorial the Agency's Program tial to affect all the patients | G | 244 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETION | |
| G 244 | evidence a plan for tadministrative review A. On 7/31/12 at 1 conference the adminidicated she has not only has problems of patient problems with nursing casually. B. On 7/31/2012 a requested a copy of performance improvant information regaliance been discussed. C. On 8/3/12 at 11 requested the QAPI administrator / direct DON indicated she coprogram. 2. On 8/3/12 at 12:00 several documents for director of nursing. The evidence a plan for the administrative review. A. A document that 4-12-12, DATE, NUM INDICATOR, COMM | ncy's policies failed to he overall policy and a a clinical record review. 15 PM, during the entrance nistrator / director of nursing data for quality assurance, n notes, and discusses in the alternate director of 13:20 PM, the surveyor the quality insurance ement program (QAPI) policy urding patient problems that d. 145 AM, the surveyor program from the or of nursing (DON). The lid not know about the QAPI 150 PM, the surveyor received rom the administrator / the documents failed to the overall policy and | G 244 | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUI | | PLE CONSTRUCTION G | (X3) DATE SUF | |
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| G 244 | title of Amazing Grace states, "IV Strengths the home care industricommunity resources Committed staff V. Wengaging additional cunderstanding and im 3. Making a profit in the payments 4. Improving billing procedures VI. Expansion into other a pediatrics and psychia areas of the state VII. regulation 2 Increased payment sources " C. A blank undated SATISFACTION SUR D. A document with Amazing Grace MC (if "Meetings held with the administrator /[dir. A.D.O.N. [the name of / director of nursing] with 5/30/2011, 6/4/11, and E. A document date handwritten title of "A (illegible word) HHA." | ument with a handwritten e My Choice (illegible word) 1. Increased knowledge of ry. 2. Knowledge of 3. Good referral base 4. eaknesses 1. Difficulty competent, dedicated staff 2. replementing new regulations are face of decreased g financial resources and OPPORTUNITIES 1. areas of home care such as atric 2. Expansion into other THREATS 1. Industry over d competition 3. Decreased document titled "CLIENT VEY" The a handwritten title of a handwritten title of a handwritten title of a handwritten title of b handwritten title of a handwritten title of a handwritten title of b handwritten administrator b handwritten administrator b handwritten title of b handwritten administrator b handwritten title of b handwritten administrator b handwritten title of b handwritten administrator | G | 244 | | | |
| | GOVERNANCE" state organizational perform | es, "12. Evaluate | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | | LE CONSTRUCTION | (X3) DATE SUR COMPLETI | |
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| G 244 | resources for the imp wide Quality Assessm Program, receive representation of the following SUPERVISION" states act as the Director of registered nurse, or not individual who has authe execution of the following the following for the following fo | elementation of an Agency nent and Performance orts and approve the Agency ivities." It titled "1.18 AGENCY es, "The Administrator may Nursing if he/she is a nay appoint another athority and responsibility for ollowing major functions: iveness of the Agency's es." I OF THE AGENCY'S Esses the extent to which the appropriate, adequate, | | 244 | | | |
| | Based on policy and review and interview, there was a plan for a the extent to which th appropriate, adequate of 1 agency with the pserved by the agency Findings include: 1. Review of the ager evidence a plan for ta the extent to which th | | | | | | |

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| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
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| G 245 | A. On 7/31/12 at 1:1 conference the admin indicated she has no only has problems on patient problems with nursing casually. B. On 7/31/2012 at requested a copy of the performance improve and information regarnave been discussed. C. On 8/3/12 at 11: requested the QAPI padministrator / director DON indicated she diprogram. 2. On 8/3/12 at 12:00 several documents frod director of nursing. The vidence a plan for the administrative review. A. A document that 4-12-12, DATE, NUME INDICATOR, COMME names. (Referenced in attachment) B. An undated documents of the community resources community resources community resources committed staff V. W | istrator / director of nursing data for quality assurance, notes, and discusses the alternate director of 3:20 PM, the surveyor ne quality insurance ment program (QAPI) policy ding patient problems that 45 AM, the surveyor rogram from the or of nursing (DON). The donot know about the QAPI PM, the surveyor received on the administrator / ne documents failed to e overall policy and states, "TYPE OF DATA: BER / NAME, ADM, MEET ENTS" is a grid with patient's nother documents in ument with a handwritten of the My Choice (illegible word) 1. Increased knowledge of | G | 245 | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUI | | PLE CONSTRUCTION G | (X3) DATE SUF COMPLET | |
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| G 245 | Understanding and im 3. Making a profit in the payments 4. Improving billing procedures VI. Expansion into other apediatrics and psychical areas of the state VII. regulation 2 Increased payment sources. C. A blank undated SATISFACTION SUR D. A document with Amazing Grace MC (imazing Grace MC (imaz | replementing new regulations are face of decreased g financial resources and OPPORTUNITIES 1. areas of home care such as atric 2. Expansion into other THREATS 1. Industry over d competition 3. Decreased document titled "CLIENT VEY" In a handwritten title of a handwritten title of a handwritten title of a handwritten title of a handwritten administrator with meeting dates 5/1/2011, and 6/18/11. and 8/15/11 with the amazing Grace My Choice The document evidenced a so of the governing body. It titled "1.10 areas of the governing body. It it is a handwritten title of and approve the Agency with and Performance orts and approve the Agency is it it is a handwritten titled "1.18 AGENCY s, "The Administrator may | G | 245 | | | |

| | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | E CONSTRUCTION | (X3) DATE SUR COMPLETI | |
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| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 872 | ET ADDRESS, CITY, STATE, ZIP CODE 17 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 245 | registered nurse, or mindividual who has au the execution of the form of the form of the form of the effection of the effecti | nay appoint another athority and responsibility for collowing major functions: iveness of the Agency's s." | | 245 | | | |
| G 248 | administrative practice reviewed to | ion process the policies and es of the agency are to which they promote propriate, adequate, | 6. | 248 | | | |
| | Based on policy and review and interview, there was a plan for the administrative practice reviewed to determine promote patient care adequate, effective and | es of the agency to be e the extent to which they | | | | | |
| | administrative practice determine the extent of patient care that is ap effective, and efficient A. On 7/31/12 at 1:1 | eview of the the policies and es of the agency to to which they promote opropriate, adequate, t. | | | | | |
| | conference the admin | nistrator / director of nursing | | | | | |

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| G 248 | indicated she has no only has problems on patient problems with nursing casually. B. On 7/31/2012 at requested a copy of the performance improve and information regard have been discussed. C. On 8/3/12 at 11: requested the QAPI padministrator / director DON indicated she diprogram. 2. On 8/3/12 at 12:00 several documents frod director of nursing. The evidence a plan for the administrative review. A. A document that 4-12-12, DATE, NUME INDICATOR, COMME names. (Referenced attachment) B. An undated documents in the community resources community resources. Committed staff V. Wengaging additional community and control of the community resources. | data for quality assurance, notes, and discusses the alternate director of 3:20 PM, the surveyor ne quality insurance ment program (QAPI) policy ding patient problems that 45 AM, the surveyor grogram from the grof nursing (DON). The dot not know about the QAPI PM, the surveyor received om the administrator / ne documents failed to e overall policy and states, "TYPE OF DATA: BER / NAME, ADM, MEET ENTS" is a grid with patient's nother documents in ument with a handwritten end My Choice (illegible word) 1. Increased knowledge of y. 2. Knowledge of 3. Good referral base 4. eaknesses 1. Difficulty ompetent, dedicated staff 2. inplementing new regulations | G | 248 | | | |

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI | | E CONSTRUCTION | (X3) DATE SUF COMPLET | |
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| | ROVIDER OR SUPPLIER | | • | 872 | EET ADDRESS, CITY, STATE, ZIP CODE 27 COMMERCE PARK PL STE L DIANAPOLIS, IN 46268 | | |
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| G 248 | payments 4. Improvir billing procedures VI. Expansion into other pediatrics and psychiareas of the state VII. regulation 2 Increase payment sources " C. A blank undated SATISFACTION SUR D. A document with Amazing Grace MC ("Meetings held with the administrator /[dir A.D.O.N. [the name of /director of nursing] v5/30/2011, 6/4/11, and E. A document dath handwritten title of "A (illegible word) HHA." meeting with member 3. The undated policy GOVERNANCE" state organizational perform Organizational Annual resources for the implement of the word of the wor | opportunities 1. areas of home care such as atric 2. Expansion into other THREATS 1. Industry over d competition 3. Decreased I document titled "CLIENT VEY" In a handwritten title of illegible word) HHA states, the D.O.N. and [the name of ector of nursing] and of the alternate administrator with meeting dates 5/1/2011, d 6/18/11. Bed 8/15/11 with the mazing Grace My Choice The document evidenced a res of the governing body. I titled "1.10 es, "12. Evaluate mance through the all Evaluation 15. Allocate dementation of an Agency ment and Performance orts and approve the Agency ivities." I titled "1.18 AGENCY es, "The Administrator may Nursing if he/she is a | G | 248 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | TIPLE CONSTRUCTION | (X3) DATE S COMPL | |
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| | ROVIDER OR SUPPLIER GRACE MY CHOICE IN | | s | TREET ADDRESS, CITY, STATE, ZIP CODE 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | | 103/2012 |
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| G 248 | d. Evaluate the effect program and service: 484.52(a) POLICY A REVIEW Mechanisms are esta collection of pertinen This STANDARD is Based on policy and review and interview, mechanisms were esta collection of pertinen for 1 of 1 agency with patients served by the Findings include: 1. Review of the age evidence mechanism for the collection of pertinen for the collection of pertinen for the collection of pertinents and the collection of pertinents are pertinent by the service of the | following major functions: tiveness of the Agency's s." ND ADMINISTRATIVE ablished in writing for the t data to assist in evaluation. not met as evidenced by: administrative document the agency failed to ensure stablished in writing for the t data to assist in evaluation in the potential to affect all e agency. ncy's policies failed to as were established in writing ertinent data to assist in 15 PM, during the entrance inistrator / director of nursing data for quality assurance, in notes, and discusses in the alternate director of 3:20 PM, the surveyor the quality insurance | G 24 | 8 | | |
| | nursing casually. B. On 7/31/2012 at requested a copy of performance improve | 3:20 PM, the surveyor the quality insurance ement program (QAPI) policy rding patient problems that | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | E CONSTRUCTION | (X3) DATE SUR COMPLETI | |
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| G 249 | C. On 8/3/12 at 11: requested the QAPI padministrator / director DON indicated she diprogram. 2. On 8/3/12 at 12:00 several documents frou director of nursing. The evidence a plan for the administrative review. A. A document that 4-12-12, DATE, NUME INDICATOR, COMME names. (Referenced in attachment) B. An undated doct title of Amazing Graces states, " IV Strengths the home care industric community resources Committed staff V. Wengaging additional counderstanding and im 3. Making a profit in the payments 4. Improving billing procedures VI. Expansion into other apediatrics and psychia areas of the state VII. regulation 2 Increased payment sources " | 45 AM, the surveyor program from the profiner of nursing (DON). The digital not know about the QAPI PM, the surveyor received on the administrator / ne documents failed to e overall policy and States, "TYPE OF DATA: BER / NAME, ADM, MEET ENTS" is a grid with patient's in other documents in Jument with a handwritten end My Choice (illegible word) 1. Increased knowledge of the case of decreased grinancial resources and OPPORTUNITIES 1. Jareas of home care such as patric 2. Expansion into other three the case of the case of the care such as patric 2. Expansion into other three th | G | 249 | | | |

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| G 249 | Amazing Grace MC ("Meetings held with the administrator /[dir A.D.O.N. [the name of / director of nursing] of 5/30/2011, 6/4/11, and E. A document dath handwritten title of "A (illegible word) HHA." meeting with member 3. The undated policy GOVERNANCE" state organizational perform Organizational Annuaresources for the impurity wide Quality Assessing Program, receive reputality assurance act 4. The undated policy SUPERVISION" state act as the Director of | n a handwritten title of illegible word) HHA states, ne D.O.N. and [the name of ector of nursing] and of the alternate administrator with meeting dates 5/1/2011, d 6/18/11. ed 8/15/11 with the mazing Grace My Choice. The document evidenced a res of the governing body. etitled "1.10 es, "12. Evaluate mance through the all Evaluation 15. Allocate dementation of an Agency ment and Performance orts and approve the Agency ivities." etitled "1.18 AGENCY es, "The Administrator may Nursing if he/she is a | G | 249 | | | |
| G 250 | the execution of the find. Evaluate the effect program and services 484.52(b) CLINICAL At least quarterly, approfessionals, represent the program, review a closed clinical records. | othority and responsibility for collowing major functions: iveness of the Agency's s." RECORD REVIEW coropriate health enting at least the scope of a sample of both active and is to determine whether re followed in furnishing | G; | 250 | | | |

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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDED TO THE APPROPRIED TO TH | ILD BE | (X5) COMPLETION DATE |
| G 250 | Continued From page | e 70 | G | 250 | | | |
| | Based on policy and review and interview, there was a plan that professionals represe program reviewed, at active and closed clir whether established furnishing services for potential to affect all pagency. | administrative document the agency failed to ensure appropriate health enting the scope of the t least quarterly, a sample of nical records to determine policies are followed in or 1 of 1 agency with the patients served by the | | | | | |
| | evidence a plan that a professionals represe program reviewed, at active and closed clir | ncy's policies failed to appropriate health enting the scope of the least quarterly, a sample of nical records to determine policies are followed in | | | | | |
| | conference the admir indicated she has no only has problems or | 15 PM, during the entrance nistrator / director of nursing data for quality assurance, notes, and discusses the alternate director of | | | | | |
| | requested a copy of t performance improve and information regal have been discussed | ement program (QAPI) policy rding patient problems that | | | | | |

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | PLE CONSTRUCTION | (X3) DATE SUR COMPLETE | |
|--------------------------|---|---|-------------------|-----|--|---------------------------|----------------------------|
| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | · | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 250 | requested the QAPI padministrator / director DON indicated she di program. 2. On 8/3/12 at 12:00 several documents fro director of nursing. The evidence a plan for the administrative review. A. A document that 4-12-12,DATE, NUME INDICATOR, COMME names. (Referenced attachment) B. An undated docutitle of Amazing Grace states, " IV Strengths the home care industric community resources Committed staff V. Wengaging additional cunderstanding and in 3. Making a profit in the payments 4. Improvin billing procedures VI. Expansion into other pediatrics and psychia areas of the state VII. regulation 2 Increased payment sources " C. A blank undated SATISFACTION SUR | PM, the surveyor received om the administrator / ne documents failed to e overall policy and States, "TYPE OF DATA: BER / NAME, ADM, MEET ENTS" is a grid with patient's nother documents in Lument with a handwritten end My Choice (illegible word) 1. Increased knowledge of y. 2. Knowledge of y. 2. Knowledge of 3. Good referral base 4. eaknesses 1. Difficulty competent, dedicated staff 2. aplementing new regulations are face of decreased grinancial resources and OPPORTUNITIES 1. areas of home care such as artic 2. Expansion into other THREATS 1. Industry over discompetition 3. Decreased document titled "CLIENT" | G | 250 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | NAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC | | | 8727 | T ADDRESS, CITY, STATE, ZIP CODE COMMERCE PARK PL STE L IANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 250 | Amazing Grace MC ("Meetings held with the administrator /[dir A.D.O.N. [the name of / director of nursing] of / director of nursing] of // director of nursing of // director | illegible word) HHA states, ne D.O.N. and [the name of ector of nursing] and of the alternate administrator with meeting dates 5/1/2011, d 6/18/11. ed 8/15/11 with the mazing Grace My Choice The document evidenced a rs of the governing body. It titled "1.10 es, "12. Evaluate mance through the all Evaluation 15. Allocate lementation of an Agency ment and Performance orts and approve the Agency | G | 250 | | | |
| G 251 | SUPERVISION" states act as the Director of registered nurse, or n individual who has authe execution of the fid. Evaluate the effect program and services 484.52(b) CLINICAL There is a continuing each 60-day period the health services to determine the continuity of the continuity o | nay appoint another thority and responsibility for collowing major functions: iveness of the Agency's s." | G | 251 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | PLE CONSTRUCTION G | (X3) DATE SURVI | |
|---|--|---|-------------------|-----|--|--------------------|--------|
| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| NAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC | | | | 8 | REET ADDRESS, CITY, STATE, ZIP CODE 1727 COMMERCE PARK PL STE L NDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | SHOULD BE COMPLETI | |
| G 251 | Based on policy and review and interview, there was a plan for a records of each 60 da receives services to oplan of care and appropriate continuation of care for potential to affect all pagency. Findings include: 1. The agency documentere was a plan for a records for each 60 d services or that any refor patients on services. A. On 7/31/12 at 1:15 conference the admin no data for quality asson notes, discusses palternate director of n documents. B. On 7/31/2012 at requested a copy of the performance improve policy, and information problems that have be surveyor explained to C. On 8/3/12 at 11:4 requested the QAPI padministrator/director indicated she did not | administrative document the agency failed to ensure a continuing review of clinical ty period that the patient tetermine adequacy of the opriateness of the or 1 of 1 agency with the patients served by the ments failed to evidence a continuing review of clinical ay period a patient receives eview had been completed ay period a patient receives eview had been completed as for 2011 and 2012. The PM, during the entrance istrator indicated she has surance, only has problems that the problems with the tursing casually and The quality insurance ment program (QAPI) on regarding patient the discussed. The the DON. The SAM, the surveyor program from the of nursing (DON). The DON | G | 251 | | | |

| | DF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII | | LE CONSTRUCTION | (X3) DATE SURVE' COMPLETED | |
|--------------------------|--|---|-------------------|-----|--|----------------------------|--------|
| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| | ROVIDER OR SUPPLIER GRACE MY CHOICE INC | ; | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | SHOULD BE COMPLE | |
| G 251 | several documents fro administrator/director | PM, the surveyor received om the of nursing. The documents an for the overall policy and | G | 251 | | | |
| | 4-12-12,DATE, NUME INDICATOR, COMME | states, "TYPE OF DATA: BER/NAME, ADM, MEET ENTS." The document is a nes. (Referenced in other nent) | | | | | |
| | of Amazing Grace My states, " IV Strengths the home care industrommunity resources Committed staff V. W engaging additional c Understanding and in 3. Making a profit in the payments 4. Improvin billing procedures VI. Expansion into other a pediatrics and psychia areas of the state VII. | 3. Good referral base 4. eaknesses 1. Difficulty ompetent, dedicated staff 2. aplementing new regulations are face of decreased g financial resources and | | | | | |
| | D. A document with Amazing Grace MC (i states, "Meetings held | n a handwritten title of llegible word) HHA that d with the D.O.N. and (the rator/director of nursing) and | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------|---|--|-------------------------------|----------------------------|
| | | 012649 | B. WIN | | | | |
| NAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC | | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | 00/0 | 0/2012 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 251 | E. A document dath handwritten title of "A (illegible word) HHA. meeting with member F. A document und QUALITY ASSESSM IMPROVEMENT INIT 3. The undated policy GOVERNANCE" stattorganizational perform Organizational Annuaresources for the impudie Quality Assessm | of nursing) with meeting 2011,6/4/11, and 6/18/11. ed 8/15/11 with the Amazing Grace My Choice The document evidences a rs of the governing body. ated and titled, "8.6 ENT AND PERFORMANCE TATIVES" at, titled, " 1.10 es, "12. Evaluate mance through the all Evaluation. 15. Allocate elementation of an Agency ment and Performance orts and approve the Agency | G | 2251 | | | |
| G 332 | SUPERVISION states act as the Director of registered nurse, or nindividual who has authe execution of the five Evaluate the effective program and services 484.55(a)(1) INITIAL. The initial assessmen within 48 hours of refit the patient's return he physician-ordered states. | nay appoint another ithority and responsibility for collowing major functions: d. eness of the Agency's s." ASSESSMENT VISIT at visit must be held either erral, or within 48 hours of ome, or on the | G | 3332 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0: | 3/2012 |
| NAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC | | | | 87 | EET ADDRESS, CITY, STATE, ZIP CODE 727 COMMERCE PARK PL STE L IDIANAPOLIS, IN 46268 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETION DATE |
| G 332 | assessment visit was referral of 1 of 12 pat with the potential to a agency. Findings include: 1. Clinical record #9, was referred for hom assessment visit was The clinical record eventhe administrator / dir " 02/24/12 11 AM, [the referred from [the nathrough the social wowas made to [the nare assessment and administration of the nare assessment and administrati | e 76 If failed to ensure the initial of made within 48 hours of ient records reviewed (#9) affect all new patients of the start of care date 2/28/12, which is not completed until 2/28/12. It | G | 3332 | | | |
| G 337 | conference the admir indicated she comple within 48 hours unles 484.55(c) DRUG REG | PM, during the entrance nistrator/director of nursing stes admission assessments as the patient declines. GIMEN REVIEW assessment must include a ons the patient is currently | G: | 337 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 012649 | B. WIN | G | | 08/0 | 3/2012 |
| | IAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 8727 COMMERCE PARK PL STE L INDIANAPOLIS, IN 46268 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 337 | using in order to identerects and drug reactories and drug reactories and drug reactories and trug interactions, dup noncompliance with compliance and some profile was and 9) records review affect all the patients. 1. Clinical record #3, evidenced a skilled not documented Lasix was (milligrams) to 20 mg administration record documentation of the 2. Clinical record #8, evidenced documentation of the 2. Clinical record #8, evidenced documentation of the 3. Clinical record #9, to evidence a medical 4. The undated policy RECORD CONTENT orders that include minimal compliance with contract to the compliance of the compliance and compliance with compliance and compliance and compliance with compliance and compliance and compliance with compliance and compliance and compliance and compliance with compliance and | tify any potential adverse tions, including ineffective ant side effects, significant officate drug therapy, and drug therapy. Into the as evidenced by: Ford review, and policy illed to ensure the seaccurate for 3 of 12 (#3, 8) Ford with the potential to off the agency. Start of care 1/24/12, and the agency of the agency. Start of care 1/24/12, and the agency of the agency o | | 337 | | | |
| G 341 | RECORD CONTENT orders that include m 484.55(d)(3) UPDATE | S" states, "s. physician edications." E OF THE | G | 341 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|--------------------|--------|---|-------------------------------|--------|--|
| | | 012649 | B. WIN | | | 08/0 | 3/2012 | |
| NAME OF PROVIDER OR SUPPLIER AMAZING GRACE MY CHOICE INC | | | • | 872 | T ADDRESS, CITY, STATE, ZIP CODE COMMERCE PARK PL STE L COMMENS, IN 46268 | , 33.0 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | JLD BE | (X5) COMPLETION DATE | | | |
| G 341 | The comprehensive a updated and revised of the OASIS) at disc. This STANDARD is a Based on clinical recagency failed to ensu discharge assessment closed records review affect all the agency's Findings include: 1. Clinical record # 1 discharged on 2/8/12 evidence a comprehe assessment had been comprehed | essessment must be (including the administration harge. Interest as evidenced by: Ford and policy review, the are a comprehensive in the was completed for 2 of 4 and with the potential to a patients. (#1 and 9) evidenced the patient was in the record failed to ensive discharge in completed. evidenced the patient was in the record failed to ensive discharge in completed. | G | 341 | | | | |